provides high fidelity and widespread access to the core benefits of the in-person MBCT program[9]. Second, a clear understanding of the type and amount of practice required to achieve positive clinical outcomes still eludes the field. Perhaps the most reliable finding is that program benefits have been associated with formal (30-40 min) compared to informal (3-5 min) mindfulness practice[10]. As the evidence base evolves, it can be expected that the establishment of competency standards for clinicians working within the MBCT model will yield more targeted recommendations regarding optimum levels of practice density.

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Bodily distress disorder in ICD-11: problems and prospects

Classifying the disorders associated with burdensome somatic concerns has been a challenging exercise in psychiatric nosology[1]. The classifications of these conditions in ICD-10 and DSM-IV have not fared much better than earlier attempts[2]. Even though not exactly identical, these classifications were broadly similar and criticisms of either system are therefore generally applicable to both. Among the most salient criticisms are those relating to their utility in routine clinical practice. These include the rarity of the major categories of the group, both in the community and in general clinical practice, as well as the evidence suggesting poor diagnostic reliability[3].

A central feature of the definition of these disorders, that the symptoms are not due to physical or medical causes, has been criticized for being unreliable and for posing a fundamental nosological problem: defining a disorder on the basis of the absence of a feature rather than the presence of a problem[4]. Labels assigned to burdensome somatic preoccupations that have come to be seen as pejorative create another problem for clinical utility. Some patients object to the term "somatoform", which they think may imply that their symptoms are of doubtful clinical importance and are "in their heads" or not real. Furthermore, the notion that the symptoms are medically unexplained is often rejected by patients as essentially an issue of detection.

As part of the activities designed to lead to the approval of ICD-11 by the World Health Assembly in 2018, the World Health Organization, through its International Advisory Group[5], constituted the Somatic Distress and Dissociative Disorders Working Group, which, among other tasks, was asked to propose changes to the section on somatoform disorders in ICD-10. The Working Group has proposed a new and much simplified category of bodily distress disorder, which replaces all of ICD-10 categories within the group of somatoform disorders (F45.0) and, to a large extent, neurasthenia (F48.0), bringing these together under a single category. The only ICD-10 somatoform condition excluded from BDD is hypochondriasis (F45.2).

In the proposed new classification, bodily distress disorder is defined as "characterized by the presence of bodily symptoms that are distressing to the individual and excessive attention directed toward the symptoms, which may be manifest by repeated contact with health care providers. If a medical condition is causing or contributing to the symptoms, the degree of attention is clearly excessive in relation to its nature and progression. Excessive attention is not alleviated by appropriate clinical examination and investigations and appropriate reassurance. Bodily symptoms and associated distress are persistent, being present on most days for at least several months, and are associated with significant impairment in personal, family, social, educational, occupational or other important areas of functioning. Typically, the disorder involves multiple bodily symptoms that may vary over time. Occasionally there is a single symptom – usually pain or fatigue – that is associated with the other features of the disorder" (this is the proposed brief definition for bodily distress disorder; for the format of ICD-11 diagnostic guidelines, see First et al[6]).

Responding to the same set of criticisms, the DSM-5 created a new grouping called Somatic Symptom and Related Disorders, in which the prototypic condition is somatic symptom disorder. Even though this diagnosis can be given to a condition with "one or more somatic symptoms", it nevertheless requires that "excessive thoughts, feelings, or behaviors are related to the somatic symptoms or associated health concerns". Specifically, for a diagnosis of somatic symptom disorder, at least one of three psychological criteria should be present: health anxiety, disproportionate and persistent concerns about the medical seriousness of the symptoms, and excessive time and energy devoted to the symptoms or health concerns.

In both the proposed bodily distress disorder and somatic symptom disorder, the most fundamental revision has been the abolition of the distinction between medically explained and medically unexplained somatic complaints. On the other

hand, there are now specific psychological criteria that need to be fulfilled before the diagnosis can be given. The revised classifications thus address the problem of defining somatoform disorders on the basis of the absence of a feature (a physical or medical cause) by specifying the features that must be present, such as distress and excessive thoughts and behaviors[7].

Dropping the criterion of "medically unexplained" is not without its consequences and has been criticized in somatic symptom disorder. It has been argued that patients with medical conditions and with a justifiable reason for somatic complaints may receive an inappropriate psychiatric diagnosis, with the possibility of associated stigma[8]. The specification in bodily distress disorder that "if a medical condition is causing or contributing to the symptoms, the degree of attention is clearly excessive in relation to its nature and progression" is meant to address this concern.

A single somatic symptom may lead to a diagnosis of bodily distress disorder or somatic symptom disorder. A good justification for this revision is that a single symptom, for example pain, may sometimes be as bothersome as multiple somatic symptoms. However, the point has been made that this lowering of the threshold for the diagnosis may lead to an inappropriate labeling of apparently healthy persons as having a psychological disorder[8]. This concern is addressed in bodily distress disorder by the requirement that other features, in particular associated psychological features, as well as significant functional impairment, be present before the diagnosis is given. Also, further information is provided in the proposed diagnostic guidelines that seeks to delineate mild bodily distress disorder from normal somatic concerns which may exist in the community and do not require clinical attention.

One of the important differences between the proposed ICD-11 and the DSM-5 approaches is the name of the prototype disorder. While the DSM-5 has retained the word "somatic", the proposed ICD category has avoided this term altogether. While no label can prevent completely the risk of negative connotations and misinterpretations, a more descriptive label that avoids the term "somatic" might prove more acceptable to both patients and primary care clinicians.

While the DSM-5 has retained hypochondriasis (or health anxiety) within the cluster of Somatic Symptom and Related Disorders, the current proposal for ICD-11 has placed hypochondriasis within the grouping of Obsessive-Compulsive and Related Disorders. The position of DSM-5 is supported by evidence suggesting a high co-occurrence of hypochondriasis with somatization disorder as well as shared cognitive perceptual styles between the two conditions. On the other hand, the position of the ICD-11 Working Group is supported by findings associating repetitive cognition and behaviors as well as task-related neural activation patterns on brain imaging with hypochondriasis[1]. Also, there is evidence that, unlike somatization disorders, hypochondriasis responds to some treatments used for obsessive-compulsive and related disorders[9].

The new proposals for bodily distress disorder are being systematically tested in the field studies conducted as part of the ICD revision process. These studies include Internet-based approaches, in which a large number of clinicians participate through the Global Clinical Practice Network (http://gcp.network), as well field studies conducted in clinical settings. It is hoped that the findings from the field studies will provide opportunities for a further strengthening of the utility and validity of the classification of burdensome somatic concerns in ICD-11 prior to its approval by the World Health Assembly.

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